House Commerce Committee Amendment NO. 1

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AMENDMENT NO._____

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AMEND Senate Bill No. 1346* House Bill No. 1066

by deleting the amendatory language of Section 1 in its entirety and inserting in lieu thereof the following:

Section ___. (a) As used in this section, unless the context otherwise requires:

(1) "Emergency medical condition" means the sudden onset of a health condition that requires immediate medical attention, where failure to provide medical attention for those presenting symptoms could reasonably be expected to result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or could reasonably be expected to place the person's health in serious jeopardy.

(2) "Emergency services" means health care items and services furnished in a hospital which are required to determine, evaluate and/or treat an emergency medical condition, until the condition is stabilized, as directed or ordered by a physician or directed by physician or hospital protocol.

(3) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer, other plans administered by the state government, or any certificate issued under any such policies, contracts or plans. "Health benefit plan" does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, Medicare

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supplement as defined in Section 1882(g)(1) of the Social Security Act, specified disease, vision care, other limited benefit health insurance, coverage issued as a supplement to liability insurance, workers compensation insurance, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(4) “Health insurer” means any entity offering a health benefit plan as defined in (c) above.

(5) “Participating provider” means a provider who, under a contract with the health insurer or with its contractor or subcontractor, has agreed to provide one or more health care services to enrollees of the health insurer’s health benefit plan with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health insurer.

(6) “Provider” means a physician, hospital or other person which is licensed, accredited or certified to perform specified health care services pursuant to Titles 63 , Chapters 6 or 9, or 68, Tennessee Code Annotated.

(7) “Physician” means a person licensed or permitted to practice medicine and surgery under Title 63, Chapter 6 or 9, Tennessee Code Annotated.

(8) “Stabilized” means with respect to an emergency medical condition, that no material deterioration of the condition is likely, within a reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

(b)(1) A health benefit plan shall not deny coverage for emergency services if the symptoms presented by an enrollee of a health benefit plan and recorded by the attending provider indicate that an emergency medical condition could exist, regardless of whether or not prior authorization was obtained to provide those services and regardless of whether or not the provider furnishing the services has a contractual agreement with the health benefit plan for the provision of such services to such enrollee.

(2) If a participating provider or other authorized representative of a health insurer authorizes emergency services, the health insurer shall not subsequently rescind or modify that authorization after the provider renders the authorized care in good faith and pursuant to the authorization except for payments made as a result of misrepresentation, fraud, omission or clerical error.

(3) Once an enrollee is stabilized pursuant to subsection ( )(h), a health benefit plan may require as a condition of further coverage that a provider shall promptly contact the health insurer for prior authorization for continuing treatment, specialty consultations, transfer arrangements or other medically necessary and appropriate care for an enrollee.

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(4) Coverage of emergency services shall be subject to applicable copayments, coinsurance and deductibles.